WALKER COUNTY DEPARTMENT OF EDUCATION
OFFICE OF SCHOOL NUTRITION
P.O. BOX 29
LAFAYETTE, GEORGIA 30728
Phone: 706/638-7971
Fax: 706/638-1289

To: Parents

From: Michelle Coker, School Nutrition Coordinator

Re: Annual Meal Substitutions for Medical or Dietary Reasons

In the Walker County School System, the School Nutrition Program wants to meet the dietary needs of all students. If your child needs to have substitutions or modifications made in their meal, due to a medical or special needs restriction, we will be pleased to make those changes.

In order to make modifications; we must have on file in school nutrition a statement signed by a medical doctor, which includes the food to be omitted from the student's diet and a choice of several foods that may be substituted. This medical documentation must be filled out **at the beginning of each new school year.** Therefore, please have the Doctor complete the attached form immediately and return in the enclosed envelope. You may also turn the form into the school's cafeteria Manager at the beginning of next school year. If the authorized substitute foods are not normally kept in inventory, the parents should provide the substitute food prescribed by the physician.

If you have any other questions concerning your child's breakfast or lunch, please call me at (706) 638-7969.

Thank you.

MC/pj

If you need assistance with this form, contact Kayla Flowers at 706-639-1715 or kaylaflowers@walkerschools.org .

STATEMENT TO REQUEST ACCOMMODATIONS FOR SPECIAL DIETARY NEEDS IN THE SCHOOL MEAL PROGRAMS

Please read guidance and instructions on page 3 before completing this form.

Part 1: To be completed by Parent/Guardian			
Child's Name	Date of Birth	School Name	Grade/Classroom
Parent/Guardian Name (Please Print)	Phone Number	Email Address	
Parent's Signature		Date	

Part 2: Disabilities – Complete all sections applicable.	
Please provide a description of the child's physical or mental impairment and how it restricts the child's diet.	
Please explain how to accommodate the disability.	
List any dietary restrictions or special diet instructions for school meals.	
List food(s) to be omitted from diet: _____ _____ _____ _____	List food(s) to be substituted: _____ _____ _____ _____
Designate texture modifications needed for all foods: ☐ Pureed ☐ Diced/finely ground ☐ Chopped/cut into bite-sized pieces	Designate consistency for liquids: ☐ Pudding thick ☐ Nectar thick ☐ Honey thick ☐ Thin/normal consistency
List any special equipment or utensils needed:	
Additional comments about the child's eating or feeding patterns:	

Signature Below (See Guidance and Instructions on page 2). Required for accommodations outside the meal pattern.	
Signature of State Licensed Healthcare Professional	Date
State Licensed Healthcare Professional's Name, Title & Phone Number (Please Print)	Date

Health Insurance portability and Accountability Act Waiver

In accordance with the provision of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school / program) and I consent to allow the physician / medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____(date).

This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent/guardian of official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent / Guardian Signature:_____ Date:_____
(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

If you have difficulty communicating with us or understanding this information because you do not speak English or have a disability, please let us know. Contact 706-638-7971. Free language assistance or other aids and services are available upon request.

Si tiene dificultades para comunicarse con nosotros, o para entender esta información porque no habla inglés o tiene alguna discapacidad, por favor infórmenos. Comuníquese con 706-638-7971. Tenemos disponibilidad de servicios gratuitos de ayuda en otros idiomas y otro tipo de asistencia y servicios cuando lo solicite.

GUIDANCE AND INSTRUCTIONS TO REQUEST ACCOMMODATIONS FOR SPECIAL DIETARY NEEDS IN THE SCHOOL MEAL PROGRAMS

The medical statement on page 1 must be completed and submitted to <insert facility name> before any meal substitutions can be made. If changes are needed, the parent/guardian is required to submit a new form.

Guidance

Disability

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act (ADAAA) of 2008, "a person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. According to the ADAAA, most physical and mental impairments constitute a disability.

Major life activities include, but are not limited to, caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentration, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

U.S. Department of Agriculture (USDA) regulations require reasonable modifications to school meals to accommodate children with disabilities when the disability restricts the child's diet. Modifications will be determined on a case-by-case basis.

Accommodations for special dietary requests that can be made within the Program meal pattern requirements do not require a medical statement. The School Food Authority may require a medical statement signed by a State licensed healthcare professional be submitted to accommodate the request.

State Licensed Healthcare Professional is a professional who is authorized to write medical prescriptions under State law, and may include a physician, nurse practitioner, or a physician's assistant. Please refer to the Medical Association of Georgia, ***Georgia Prescribers Chart***: http://www.mag.org/sites/default/files/downloads/georgia-prescribers-chart.pdf.

Instructions

Part 1: To be completed by the parent/guardian for all special dietary requests.
Part 2: Please provide sufficient detail for the school food service to make appropriate accommodations. This section must be completed and signed by a State licensed healthcare professional when the modified meal does not meet the Program meal pattern requirements. The district Section 504 Coordinator, School Food Service Professional and/or other team member will work with you to manage the process of meal modifications.
Signature: Signature from a State licensed healthcare professional is required when the reasonable modification does not meet the Program meal pattern requirements.